

Legislative
Snapshot:
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MENTAL HEALTH

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MENTAL HEALTH

by
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MENTAL HEALTH

A Snapshot of 1980 Laws

Donna Potemken

The states have traditionally played an important role in the area of mental health. State and local governments have been responsible for the care of the mentally ill since the late eighteenth century. In 1977 the states spent over \$4.1 billion on mental health, according to the National Association of State Mental Health Program Directors. Expenditures in mental health institutions accounted for 75 percent (\$3.1 billion) while community programs comprised the other 25 percent (\$1.1 billion).

New York and California were two of the first states to enact community mental health legislation. The law in New York was passed in 1954; the California law was adopted in 1957. State legislation, as well as the Community Mental Health Centers Act signed into law by President John F. Kennedy in 1963, helped to refocus the provision of mental health services from a predominantly institutional-based system to a community-based one. By 1976, 27 states had enacted community mental health legislation. Such laws often provided state aid to local governments for the operation of outpatient clinics, the provision of psychiatric care in general hospitals, and other mental health services in the community.

The deinstitutionalization movement gained momentum in 1961 with the release of the Joint Commission on Mental Health report entitled *Action for Mental Health*. The Commission stated that the needs of the mentally disabled could best be served by returning them to the community. The intention was that the appropriate social and medical support services could be provided in a community setting, using the hospital only as a last resort.

Two court decisions in the 1970s gave further impetus to deinstitutionalization. In *Wyatt v. Stickney*, the right to treatment was established, justifying confinement only if an institution could meet basic standards of therapeutic care. *O'Connor v. Donaldson* decided that a state may not involuntarily confine, with only custodial care, any mental patient who is not dangerous and is capable of functioning in society.

In 1980, 16 state legislatures passed laws directed at the provision of community mental health services. **ALABAMA** and **COLORADO** enacted laws dealing with the corporate aspects of mental health institutions. The **ALABAMA** law (SB 505) established guidelines for the composition of the boards of directors of regional mental health facilities, while the **COLORADO** legislation (HB 1109) eliminated the requirement that a community mental health center be a nonprofit corporation.

Eight laws were adopted relating to financing mental health services. **CALIFORNIA**, **NEW YORK**, **VERMONT** and **VIRGINIA** each addressed the problem of funding community-based mental health facilities. **CALIFORNIA** SB 1984 fosters the growth of mental health facilities designed to provide community-based treatment. This legislation appropriates funds specifically for the construction of a mental health complex in San Joaquin County. The mental hygiene law in the State of **NEW YORK** was amended to fund community residential services for the mentally retarded and mentally disabled. **VERMONT** HB 214 provides funding for community mental health services programs and establishes the powers of the commissioner of mental health. **VIRGINIA** HJR 16 changes the relative proportion of state funds that are allocated to state institutions and community-based services. Legislation in **OHIO** and **MARYLAND** focused on providing mental health benefits under Medicaid.

CALIFORNIA SB 1811 stipulates that health care service plans and individual practice associations which offer mental health benefits shall try to make the services of a licensed psychologist available to their members. **TENNESSEE** amended its law, mandating that certain benefits for outpatient expenses at community health centers be covered under private health insurance.

CALIFORNIA enacted two laws (AB 2210 and AB 2738) in 1980 that contained requirements for the county Short-Doyle plans. Under the Short-Doyle Act, the county is the local unit of government that provides mental health services. The county has the responsibility to develop and adopt a mental health program which specifies that services be provided in county facilities, state hospitals, and through private agencies. A county plan establishes the basis for the state/local matching fund formula. A county plan shall provide for the most economical, coordinated and comprehensive utilization of existing public and private agencies, licensed private institutions and personnel. The Short-Doyle plans shall also include a description of the indirect and supportive services necessary to operate the county's mental health program.

Three laws were passed in 1980 which addressed the health manpower needs of mental health facilities. **CALIFORNIA** enacted two laws pertaining to mental health professionals: AB 2210 states that marriage, family and child counselors shall participate in the county Short-Doyle plans, while SB 1811 encourages the use of licensed psychologists. A **MARYLAND** law (HB 1321) establishes a system for determining the number of direct care staff in a residential facility for the mentally retarded.

Community-based mental health services were the focus of 13 laws in 7 states. **GEORGIA** and **INDIANA** passed legislation pertaining to respite care. A respite care admission is one which temporarily relieves parents or guardians of the responsibility of caring for mentally ill individuals by admitting them for 60 to 90 days to a state institution, the alternative being full-time institutionalization. **CALIFORNIA** AB 2495 provides temporary leaves of absence for Medi-Cal recipients in therapeutic or rehabilitative mental health programs. Statutes in **INDIANA** and **RHODE ISLAND** stress family boarding homes as an alternative to institutionalized care.

CALIFORNIA enacted four laws affecting the provision of community mental health services. SB 1609 provided for the establishment of a three-year pilot project in an occupational training program in Fresno County. Several sections of the California Welfare and Institutions Code were amended with regard to conservatorships. A conservator is an individual, appointed by the court, who is responsible for the finances of an individual. AB 2738 specifies that a county Short-Doyle plan include a statement of need for extramural crisis intervention and a plan for providing these services. AB 3319 authorized several other types of mental health services, including a transitional residential program and a volunteer-based companion program.

The **HAWAII** and **VIRGINIA** legislatures adopted legislation designed to strengthen their present mental health systems. **HAWAII** SB 2665-80 delineates the need for, and the establishment of, a statewide system of residential treatment programs. The **VIRGINIA** law (SJR 12) calls for the development of a timetable for the reorganization of the facilities in the state's mental health, mental retardation and substance abuse system. **VIRGINIA** HJR 9 specifies that services for the mentally handicapped must range from independent community life to institutionalization. **MICHIGAN** passed legislation which establishes county community mental health programs and outlines the powers and duties of the department of mental health.

TENNESSEE passed legislation (SB 1668) which redefined mental health terminology. **OHIO** passed similar legislation (HB 965) which included mental retardation terminology as well.

The mental hygiene law in **NEW YORK** was amended by S 9443-A to apply to the development of written service plans.

A **MAINE** law (H 1683) provides for the return of patients to mental health institutions when they fail to return from a community visit.

FLORIDA SB 584 stipulates that sites for group home facilities and foster care facilities shall be included in the housing element of a local government's comprehensive plan.

STATE-BY-STATE SUMMARY OF 1980 ENACTMENTS RELATING TO MENTAL HEALTH

ALABAMA

S 505, Act 794—This law relates to the composition of the boards of directors of regional mental health facilities. In Alabama a public corporation consisting of a minimum of three persons may contract with the State Board of Health or the Alabama Mental Health Board to construct and operate facilities and to carry out programs in particular areas. Each corporation shall be governed by a board of nine or more directors. A governing body is defined as the county commission of a county or the council, commission or other like governing body of a municipality. Three members of the board are to be appointed by each governing body which authorized the formation of the corporation. If the formation of the board was authorized by only two governing bodies, each of them shall be entitled to appoint at least five members of the board, or another member provided by the certification of incorporation.

CALIFORNIA

SB 1984, Chapter 1239—The intent of this legislation is to construct mental health facilities for community-based treatment and reduce the need for state hospitals. This bill appropriates funds to San Joaquin County to build a mental health complex. These funds may not be used for acute hospital beds, except for psychiatric facilities. Funding would be on an 85 percent state, 15 percent county cost-sharing basis.

AB 3319, Chapter 359—The counties in California are presently authorized to implement a community residential system, with specified eligibility criteria and program elements, including socialization centers. This law incorporates adult education support programs into the socialization centers. System program elements are expanded to include an in-home treatment program and a volunteer-based companion program.

SB 1811, Chapter 1235—This legislation requires that health care service plans and individual practice associations offering mental health benefits make reasonable efforts to have the services of licensed psychologists available to their members. The state reimburses local agencies and school districts for certain state-mandated costs. The Department of Finance is required to review statutes which disallow these costs, and in certain cases, make claims to the State Board of Control for reimbursement.

SB 1609, Chapter 1251—The Superintendent of Fresno County Schools is authorized to establish and maintain a three-year pilot project which extends the age limits for the occupational training program. Individuals with exceptional needs between age 21 and 25 are to be included, in addition to those under 21. The term “individuals with exceptional needs” is to be substituted for references to “persons with handicapping conditions.”

Rules and regulations to implement the pilot project will come from the Fresno County Superintendent of Schools. This bill also appropriates funds to the Department of Education from the General Fund, to be allocated to the County Superintendent for the length of the project.

AB 2495, Chapter 966—Chapter 966 of the laws of 1980 states that Medi-Cal recipients, who are involved in a therapeutic or rehabilitative mental health program in either a skilled nursing facility or an intermediate care facility, may have temporary absences from these facilities under certain circumstances. Such leaves of absence must be in accordance with the individual patient’s care program or necessary for hospitalization due to an acute condition. The state will reimburse the facility for maintaining the vacant bed at a rate less than the normal reimbursement rate. The maximum number of days allowed for absences should not be less than 30 a year.

AB 1295, Chapter 681—The Welfare and Institutions Code is amended with regard to mental health conservatorships. A conservator for a gravely disabled person can place the conservatee in his or her own home, that of a relative or, if specified by a court order, in a medical or nonmedical facility. The court in the conservatorship determines the least restrictive and most appropriate alternative and can order the conservator to place the conservatee in the least restrictive alternative.

AB 2738, Chapter 968—County mental health services provided in California are described in the County Short-Doyle plan. This legislation requires that a county Short-Doyle plan include a statement of need for extramural crisis intervention and a plan for providing these services with available funds and resources. Designated members of a mobile crisis team are now authorized to take a dangerous or gravely disabled person into custody for 72-hour treatment and evaluation.

The extramural crisis intervention plan shall include:

- 24-hour access by telephone;
- a plan for advertising the telephone service;
- a description of the composition of a mobile crisis team; and
- a plan for county-wide implementation of the extramural crisis intervention program.

AB 2210, Chapter 972—County-wide mental health services are outlined in each county’s Short-Doyle plan. Each plan shall specify how all mental health professionals can be appropriately represented and utilized in the locally administered community mental health programs. Chapter 972, Laws of 1980, provides for the participation of marriage, family and child counselors in a county Short-Doyle plan. Neither the state nor county is permitted to adopt regulations prohibiting a marriage, family or child counselor from employment in a professional, administrative or technical position in a local mental health program.

The list of professions from which a local director of mental health is to be chosen is expanded to include marriage, family and child counselors. Marriage, family and child counselors will also be included among the professions from which 5 of the 15 members of the Citizens Advisory Committee are chosen.

COLORADO

HB 1109—The General Assembly eliminated the requirement that a mental health center be a nonprofit corporation.

FLORIDA

SB 584, Chapter 89-154—The Local Government Comprehensive Planning Act of 1975 is amended to provide that sites for group home facilities and foster care facilities are to be included in the housing element of a comprehensive plan. Plans for these facilities would benefit the elderly, dependent children, physically disabled, developmentally disabled and nondangerous mentally ill persons living in normal residential communities.

GEORGIA

HB 1280, Act 1151—This act addresses respite care admissions. A respite care admission consists of an admission for a continuous period not to exceed two weeks. No more than two respite care admissions are permitted within a six-month period.

HAWAII

SB 2665-80, Act 221—The legislature declared that the state's current mental health system fails to provide adequate alternatives to institutionalization, but that the need for such alternatives exists. This law recognizes the need for a statewide system of residential treatment programs, with rehabilitative focus, which encourage the participation of clients.

The residential treatment programs shall use a case management system, with the case manager coordinating the various elements of the system and acting as an advocate for clients.

The residential treatment programs shall provide alternatives to institutional settings at each level of care. These alternatives are:

- short-term crisis residential alternatives to hospitalization for individuals experiencing an acute episode or crisis;
- long-term residential treatment programs for clients who would otherwise be living marginally in the community with little or no service support;
- transitional residential programs; and
- a semisupervised, independent but structured, living arrangement.

INDIANA

Senate Enrolled Act 236—This act allows the Department of Mental Health to institute a program of respite care for developmentally disabled and mentally ill persons. The program shall include:

- training individuals to provide respite care in their homes;

- certifying residential facilities which are suitable for providing respite care, including group homes and family boarding homes;
- contracting for respite care; and
- working with other state and local agencies to provide respite care.

The Department of Mental Health shall aid the parents or guardian of a developmentally disabled or mentally ill individual under 18 in their search for appropriate respite care with either a person or residential facility. If there is no such facility or person, or if the parent or guardian does not wish to use these services, the Department of Mental Health shall try to place the individual in a state mental institution. The individual shall be limited to 30 days respite care placement a year.

Senate Enrolled Act 103—The Department of Mental Health is authorized to place any patient of a state mental institution in a family boarding home as defined by the legislation. The Department may enter into a contractual agreement with a community mental health center to establish a family boarding home. Family boarding homes must meet the standards set up by the Department of Mental Health. The State of Indiana shall pay for the care and maintenance of patients placed in family boarding homes.

A representative of the responsible state mental institution or community mental health center is required to visit each family boarding home in which a patient is placed at least once a month. The state's representative has the authority to place the patient in a different facility if it is in the patient's best interest.

MAINE

PL 623, H 1683—This act provides for the return of patients to mental health institutions if they fail to return from community visits. The superintendent of the institution involved may request the assistance of law enforcement officials of the state or any of its subdivisions.

MARYLAND

SB 542, Chapter 324—The Department of Health and Mental Hygiene is directed to assume certain costs of medical care provided to inmates of public institutions who are eligible for federally funded Medicaid benefits. The Department shall pay the custodial authority for medical care which the individual received in the month he or she became an inmate. The Department shall be reimbursed by state and local authorities for the nonfederal costs of medical care.

HD 1321—This law establishes a system for determining the number of direct care staff in a residential facility for the mentally retarded. In order to receive federal funds, residential facilities must meet or exceed the direct care staff-to-resident ratio required by federal regulations for intermediate care facilities for the mentally retarded.

When determining the staff-to-resident ratio staff employees assigned to a living unit and professional staff assigned to provide program services shall be included. The staff employees are responsible for the physical and developmental care of the residents. The professional staff is assigned to provide program services for a specified period.

MICHIGAN

HB 5731, Public Act 423—This legislation delineates the powers and duties of the Department of Mental Health and establishes county community mental health programs.

The Department of Mental Health has the authority to:

- organize arrangements and procedures for coordination and integration of state and county program services;
- monitor the relevancy, quality, effectiveness and efficiency of county programs;
- establish financial liability schedules, provisions and procedures for persons receiving mental health services from county programs;
- consult, before planning the service, with the local government of the area where a specialized residential service is to be located; and
- establish a procedure to assure that rent for property which is to be used as a specialized community residential care facility shall be based on an independent appraisal of the fair market rental value.

The state is responsible for paying all costs of a specialized residential service, provided that it is eligible for state financial support and is not otherwise paid for by federal funds, state funds, or reimbursements from persons or insurers who are financially able to pay.

NEW YORK

S 9443-A, Chapter 341—This provision amends the state's mental hygiene law with respect to the development of written service plans. Policies are established for the discharge of patients into the community.

The discharge or conditional release of all patients from developmental centers, psychiatric centers, or psychiatric inpatient services which are subject to licensure by the Office of Mental Health shall be in accordance with a written service plan. The appropriate school district and the committee on the handicapped shall be notified regarding the proposed discharge of a patient under 21.

When the patient is about to be discharged the chief administrator of the facility providing inpatient services shall notify the local social service commissioner and the appropriate state and local mental health representatives who at that time shall prepare and implement a comprehensive written service plan.

AB 2057-A, Chapter 809—This act amends the mental hygiene law in relation to funding community residential services for the mentally retarded and the mentally disabled. A community residence is any facility which, subject to licensure by the Office of Mental Retardation and Developmental Disabilities, provides a supervised residence or residential respite service for mentally disabled persons. (Family care homes are excluded.)

The legislation identifies the duties of the Commissioner of Mental Retardation and Developmental Disabilities. The Commissioner shall:

- list reimbursable services at community residential facilities (Reimbursable services are those other than intermediate care provided at a community residential facility described by regulations of the Commissioner. Fees may be paid to the provider of these services.);
- set standards for programs funded under the legislation;

- have the authority to grant state aid for the operation of a community residential facility by paying fees for certain reimbursable services; and
- establish procedures whereby payments in addition to the clients' personal allowances may be made to operators of community residential facilities or family care homes for the replacement of necessary clothing, personal and incidental needs of clients, and their recreational and cultural activities.

The legislation also states that a client cannot be denied services because of inability to pay. Voluntary agencies and local governments may charge clients fees for the provision of reimbursable services and rent, while taking into consideration the client's ability to pay, as well as his or her health insurance coverage.

OHIO

HB 964—This legislation exempts intermediate care facilities for the mentally retarded from the maximum period which Medicaid payment allows for reserving a bed, so long as the recipient's plan of care provides for a temporary absence and federal participation in the payments is available.

HB 965—This act removed outdated terms and provisions relating to mental health and mental retardation. A differentiation is made between "patient" and "resident." A patient is a person receiving care or treatment in a program or facility that provides services to the mentally ill. A resident is a person who has been admitted to an institution for the mentally retarded, is under observation and receiving care. The term "hospital" is defined to include an entire hospital, part of a hospital, or an inpatient unit administered by a community mental health center.

RHODE ISLAND

S 2685, Substitute A, Chapter 314—A group home licensed by the state, which provides care or supervision or both to eight or less mentally disabled persons, is considered to be a family home for zoning purposes.

TENNESSEE

HB 1477, Chapter 570—The Tennessee Code Annotated, Section 56-1167, is amended with regard to benefits for conditions of mental illness and mental retardation. All insurers offering group hospital policies and group major medical policies, as well as every nonprofit hospital and medical service plan corporation which issues similar policies, after July 1, 1980, shall include certain benefits for outpatient expenses at a community mental health center. The benefits shall include treatment of mental, emotional or nervous disorders, alcoholism, drug dependence, or the medical complication of mental illness or mental retardation. Coverage is limited to no more than 30 outpatient visits per year.

This coverage shall be offered for policies and contracts delivered, or offered for delivery in Tennessee, before July 1, 1980.

SB 1668, Chapter 459—This act limits the definition of the term "health care institution" with regard to mental health. An agency, institution, facility or place which provides mental health or mental retardation services is only considered to be a health care institution if it is a hospital, skilled nursing facility, intermediate care facility or ambulatory surgical center.

VERMONT

Act 108, HB 214—The intent of this legislation is to expand community mental health services, encourage local participation in programs, authorize funding for programs by state aid, local financial support, and direct payments by patients with the ability to pay.

The Commissioner of Mental Health shall ensure that community services to mentally ill and mentally retarded persons are provided by community mental health agencies. The need for community mental health and mental retardation services in the area is to be determined by the agencies. The methods which the agencies will use to provide these services shall be included in a local community services plan.

The board of directors of a nonprofit corporation that is designated a community mental health agency by the Commissioner shall have overall responsibility and control of the planning and operation of the agency.

The Commissioner has the authority to:

- grant a community mental health agency funds to be used for carrying out its mental health-mental retardation services;
- determine whether an agency has a reasonable cost per service unit;
- establish a uniform and reasonable fee schedule for services provided to persons who can pay;
- take a variety of actions if it is determined that a local community's services plan is inadequate or if it has failed to implement an adequate plan. The Commissioner may offer technical assistance to the agency, designate another agency to provide the needed services, or directly provide or arrange for the needed services if it appears that they will not be available within a reasonable period; and
- enter into agreements with local community health agencies to establish specialized services which are needed by the mentally ill.

VIRGINIA

HJR 9—The Commonwealth of Virginia has set forth a policy to establish, maintain and support the development of an effective system of treatment, training and care for mentally ill, mentally retarded, and substance abusing citizens. Services for the mentally handicapped must be planned and provided on a continuum, ranging from independent community life to institutionalization. In addition, the system shall provide the appropriate treatment, training and care in the least restrictive environment.

A case management system at the local level shall monitor each patient's entry and progress through the system.

SJR 12—The Governor is requested by the legislature to develop a timetable for the closing, demolishing or transferring to another agency, obsolete or substandard buildings in the state's mental health, mental retardation and substance abuse system. This policy is a result of the deinstitutionalization program which has reduced the population in state institutions for the mentally ill.

HJR 16—The Commission on Mental Health and Mental Retardation supports the desire of the Commonwealth of Virginia to provide care in the least restrictive environment. The Governor is requested to increase the relative proportion of state funds for mental health, mental retardation and substance abuse that are allocated to community-based services.

By 1990, 60 percent of the state's funds for the mentally handicapped are to be allocated to state institutions and 40 percent to community mental health, mental retardation and substance abuse services.

The Intergovernmental Health Policy Project has full text copies of each of the 1980 state laws relating to mental health on file. Should a particular law or laws be of special interest, a copy can be made available free of charge. Please do *not* request all of the laws noted in this snapshot. Also, please enclose a self-addressed label — it is extremely helpful to our staff.

Note: Every attempt was made to be as comprehensive as possible in listing these state laws. Some omissions or misinterpretations, however, may occur. The Intergovernmental Health Policy Project would appreciate being notified about such problems. We also would appreciate being kept up-to-date about further activities on these issues in the states.

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Intergovernmental Health Policy Project



The Intergovernmental Health Policy Project serves a unique function in the development of the nation's health policy. It is the only university-based program in the country concentrating its research efforts exclusively on the health laws and programs of the 50 state governments. The Project provides assistance to state executive officials, legislators, legislative staff and others who need to know about important developments in other states. At the same time, the IHPP helps federal officials identify innovative state health programs and specific state problems.

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The Intergovernmental Health Policy Project has a full-time staff of five professional researchers, supplemented by graduate research assistants and consultants. The publications, research and services of the IHPP are made possible by a grant from the Office of Research, Demonstrations and Statistics, Health Care Financing Administration, DHHS, to George Washington University. (HCFA Grant #18-P-97321/3-03)

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